Washington State Health Care Authority
Public Employees Benefits Board

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2012 Retiree Coverage Election Form

- **List eligible family members you wish to cover or disenroll.**
- **If deferring PEBB retiree coverage, complete sections 1, 7 and 8 if applicable, and 9.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- If adding a dependent with a disability age 26 or older, or an extended dependent, attach appropriate dependent certification form(s). Forms are available at **www.pebb.hca.wa.gov** or by calling 1-800-200-1004.
- If you are a non-Medicare retiree and adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines described in Washington Administrative Code (WAC) 182-12-262 or the family member will not be enrolled. A list of documents we will accept is available at **www.pebb.hca.wa.gov** under *Dependent Verification*.
- If enrolling after deferring, you must attach proof of continuous medical coverage since your date of deferral.
- If you are a surviving spouse, qualified/Washington State-registered domestic partner, or dependent, provide the social security number (SSN) of the deceased retiree or employee in the "Retiree or employee information ONLY" section below. Provide **your** SSN in "Section 1: Subscriber Information."

Check One	❑ I am a new retiree or surviving dependent.	❑ I am changing an existing account.	❑ I am eligible under Plan 3, not retiring.

Retiree or employee information ONLY	Retiree or employee name	Social security number	Retirement date (mm/dd/yyyy)
For K-12 school district retirees only	School district	When does your current **school district** medical/dental **coverage end?** (mm/dd/yyyy)	
Enrollment after deferral	Date other coverage ended (mm/dd/yyyy)		

Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address	Apt./unit number	City	State	ZIP Code
Mailing address (if different from above)		City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Daytime phone number (including area code)	Home phone number (including area code)
		( )	( )

Election *Check the boxes that apply to you.*

❑ Enroll: ❑ Medical only ❑ Medical and dental

❑ Enrollment after deferral (You must provide proof of continuous coverage since your date of deferral that shows beginning and ending dates.)

Date other coverage ended _____

❑ Defer due to reason below. **If deferring, see Section 9. This defers coverage for all family members.**

❑ I am enrolled in my or my spouse's or qualified/Washington State-registered domestic partner's employer coverage that is not retiree coverage.

Deferral date _____

❑ I am enrolled in a federal retiree program (for example, TRICARE). **Deferral date** _____

❑ I am enrolled in Medicare and Medicaid with Medicare Part D. (You may enroll eligible family members in PEBB.) **Deferral date** _____

❑ Disenroll. Unless I regain eligibility, I understand that I am forfeiting all further rights to enroll in the PEBB Program.

Disenrollment date _____

Are you enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of your Medicare card to this election form if we don't already have a copy.

Part A (hospital) ❑ Yes ❑ No If yes, effective date _____

Part B (medical) ❑ Yes ❑ No If yes, effective date _____

Are you enrolled in Part D (prescription drug coverage) of Medicare? ❑ Yes ❑ No If yes, effective date _____

Are you enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date _____

Are you receiving Social Security Disability? ❑ Yes ❑ No If yes, effective date _____

(continued)

Section 2: Spouse or Qualified/Washington State-Registered Domestic Partner Information

List eligible family members you wish to cover or disenroll. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. ***If you are a non-Medicare retiree adding a spouse or partner, you must provide proof of eligibility within PEBB's enrollment timelines or the family member will not be enrolled.***

Relationship to subscriber (If adding a Washington State-registered domestic partner, please attach a completed *Declaration of Tax Status* form.)

❑ **Spouse:** date of marriage _____ ❑ **Domestic partner:** date qualified or registered _____

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address (if different from subscriber)	Apt./unit number	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	**PEBB coverage for spouse/partner**	❑ Cover ❑ Disenroll Effective date _____ Reason _____

Enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of the Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Enrolled in Part D (prescription drug coverage) of Medicare? ❑ Yes ❑ No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date _____

Receiving Social Security Disability? ❑ Yes ❑ No If yes, effective date _____

Section 3: Family Member Information (such as a child) *Use additional forms for more members.*

List eligible family members you wish to cover or disenroll. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. ***If you are a non-Medicare retiree adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines or the family member will not be enrolled.*** *If adding a child of your qualified/Washington State-registered domestic partner, also attach a* Declaration of Tax Status *form. Attach appropriate certification form(s) if enrolling a dependent with a disability age 26 or older, or an extended dependent.*

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Relationship to subscriber	Last name	First name	Middle initial

Social security number	Date of birth (mm/dd/yyyy)	Sex ❑ M ❑ F	Disabled? (*Check only if age 26 or older.*) ❑ Yes ❑ No

Street address (if different from subscriber)	Apt./unit number	City	State	ZIP Code

PEBB coverage for family member ❑ Cover ❑ Disenroll Effective date_____ Reason _____

Enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of the Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Enrolled in Part D (prescription drug coverage) of Medicare? ❑ Yes ❑ No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date _____

Receiving Social Security disability? ❑ Yes ❑ No If yes, effective date _____

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Relationship to subscriber	Last name	First name	Middle initial

Social security number	Date of birth (mm/dd/yyyy)	Sex ❑ M ❑ F	Disabled? (*Check only if age 26 or older.*) ❑ Yes ❑ No

Street address (if different from subscriber)	Apt./unit number	City	State	ZIP Code

PEBB coverage for family member ❑ Cover ❑ Disenroll Effective date_____ Reason _____

Enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of the Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Enrolled in Part D (prescription drug coverage) of Medicare? ❑ Yes ❑ No If yes, effective date _____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date _____

Receiving Social Security disability? ❑ Yes ❑ No If yes, effective date _____

(continued)

Section 4: Changes to an Existing Account

Are you making changes to an existing account? ❑ **Yes** ❑ **No** *If no, go to Section 5.*

If yes, what changes? *(Check all that apply in the sections below.)*

Changes you can make anytime *Give date of event/change* _____

❑ Name Change
❑ Address Change

❑ Disenrolling dependent(s). If disenrolling due to loss of eligibility (divorce, legal separation documented by a court order, dissolution of domestic partnership, death, or other loss of eligibility under PEBB rules), **you must submit this form no later than 60 days after the event**. If applicable, provide former dependent's new address:

_____

Additional changes you can make if a qualifying event occurs (special open enrollment)

The PEBB Program will only allow changes outside of an annual open enrollment when allowed under PEBB rules (see WACs 182-12-262 and 182-08-198). You must submit this form **no later than 60 days after the event**. However, if adding a newborn or newly adopted child, and adding the child increases your premium, you must submit this form no later than 12 months after the birth or adoption. You must provide proof of the event that created the special open enrollment.

Check the box(es) next to the change requested, and indicate the event(s) below. *Give date of event* _____

❑ Add dependent(s) ❑ Change health plan ❑ Other—explain:_____

- ❑ New spouse, Washington State-registered domestic partner, or child added to family due to marriage, Washington State-registered domestic partnership, birth, adoption, court order, or medical support order.
- ❑ Child becoming eligible as an extended dependent through legal custody or legal guardianship. *Also complete* Extended Dependent Certification *form. Forms are available at* **www.pebb.hca.wa.gov**.
- ❑ Child becoming eligible as a dependent with a disability. *Also complete* Certification of Dependents With Disabilities *form. Forms are available at* **www.pebb.hca.wa.gov**.
- ❑ Dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ❑ Subscriber or dependent having a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward group health coverage.
- ❑ Subscriber or a dependent becoming eligible or losing eligibility for premium assistance through Medicaid or a state Children's Health Insurance Program (CHIP).

The following events also allow a health plan change:

- ❑ Subscriber or dependent having a change in residence that affects health plan availability.
- ❑ Subscriber or dependent becomes entitled to Medicare, or enrolls in or disenrolls from a Medicare Part D plan.
- ❑ Subscriber or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA).

Section 5: Medical Plan Selection *Check only one.*

Contact plans for benefits information; their contact information is at the end of this form.

Group Health Cooperative [1]
- ❑ Group Health Classic
- ❑ Group Health Consumer-Directed Health Plan [2]
- ❑ Group Health Medicare Plan [3]
- ❑ Group Health Value

Kaiser Foundation Health Plan of the Northwest [1]
- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Consumer-Directed Health Plan [2]

❑ Medicare Supplement Plan F, administered by Premera Blue Cross [4]

Uniform Medical Plan, administered by Regence BlueShield of Washington
- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan [2]

[1] **These plans offer Medicare Advantage plans to Medicare enrollees in certain counties. Complete and attach the *Medicare Advantage Plan Election Form* (form C) if you live in a county where Medicare Advantage is available.**

[2] **These plans are available only to retirees not enrolled in Medicare. If you cover a dependent enrolled in Medicare you must cancel your dependent's PEBB coverage before you can enroll in this plan.**

[3] **If you cover family members not enrolled in Medicare, also check Group Health Classic or Group Health Value for your family members' non-Medicare coverage.**

[4] **Complete and return form B to enroll in Medicare Supplement Plan F. PEBB does not offer the high-deductible Plan F.**

Section 6: Dental Plan Selection *Check only one. **You must enroll in medical coverage to enroll in dental.***

If you select dental coverage for yourself, you must keep dental coverage for at least two years. However, you may change dental plans within those two years. Contact plans for benefits information; their contact information is at the end of this form.

Preferred Provider Organization

❑ Uniform Dental Plan, administered by Washington Dental Service (Group #3000)
(may receive services from any provider)

Managed Care Plans

❑ DeltaCare, administered by Washington Dental Service (Group #3100)
Dentist name or clinic code _____
(must receive services from a DeltaCare provider)

❑ Willamette Dental of Washington, Inc.
Clinic location _____
(must receive services from a Willamette Dental Group provider)

❑ **Cancel Dental** I understand that I may only cancel this coverage if I have maintained enrollment in a PEBB dental plan for at least two years or if I am deferring or disenrolling from my PEBB account as allowed under PEBB rules (see Section 9). If I cancel dental for myself, dental is automatically cancelled for my enrolled dependents.

(continued)

Section 7: Life Insurance Enrollment Information

Retiree Term Life Insurance is **only available** to those who received PEBB employee life insurance. You must apply for Retiree Term Life Insurance at the time of retirement. The cost is $6.57 per month regardless of age.

Disabled retirees who qualify for the waiver of premium benefit under the PEBB employee life insurance plan are not eligible for this Retiree Term Life Insurance Plan.

Age at Time of Death	Under 65	65 through 69	70 and over
Amount of Coverage	$3,000	$2,100	$1,800

I hereby elect to enroll in the PEBB Retiree Term Life Insurance Plan. ❑ **Yes** ❑ **No**

Beneficiary _____ Beneficiary's SSN _____

Relationship to retiree _____ Beneficiary's date of birth _____

Beneficiary's address _____

Section 8: Authorization for Premium Payment

I authorize the Department of Retirement Systems to deduct from my retirement allowance the amount I am required to pay for this coverage.

❑ Yes, deduct from my pension.

❑ No, I will send my payment monthly. (You must make the first payment before you will be enrolled. Make check **payable to the Washington State Treasurer** and send with this form to Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695.)

Section 9: Signature *Required*

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we are eligible. To the extent permitted by law, PEBB may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

If adding a domestic partner to my account, I declare that my partner and I have registered through the Washington Secretary of State's Office.

If I send payment, this does not mean I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for me and my family members. If I am not enrolled in Medicare and apply to add a dependent to my PEBB coverage, I must provide copies of documents that verify the dependent's eligibility within PEBB's enrollment timelines in WAC 182-12-262 or PEBB will not enroll him or her. If we do not qualify, I will receive a refund.

I understand that if I enroll in dental, I must remain enrolled for at least two years.

If I choose to defer medical/dental, I understand I can reenroll no later than **60 days** after losing other health coverage or during the annual open enrollment period with proof of continuous enrollment. If I defer enrollment for myself, I cannot enroll my eligible family members.

I can defer enrollment in a PEBB health plan for:

- Comprehensive, employer-sponsored medical coverage that is not retiree coverage.
- Medicare Part A and Part B and Medicaid with Medicare Part D. (You may enroll your family members in PEBB coverage in this case.)
- Federal retiree coverage (may only enroll in PEBB health plan[s] once).

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the PEBB Program will direct a portion of my monthly premium to an HSA based on the information I have provided, and that there are limits to these contributions and my HSA contributions, if any, under federal tax law.

If I die, my eligible surviving family members must complete an enrollment form to enroll in or defer PEBB retiree insurance coverage no later than **60 days** after my death.

This form replaces all *Retiree Coverage Election Forms* previously submitted to PEBB. If I previously elected retiree term life insurance it will remain in effect until I cancel it.

If you are a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share your information with the DRS to better serve you.

HCA's Privacy Notice: We will keep your information private as allowed by law. To receive our Privacy Notice, call 360-923-2822 (effective January 1, 2012, call 360-725-0442) or go to **www.hca.wa.gov.**

Subscriber's signature _____ **Date** _____

Be sure to sign and date this form. Return to:

Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684 **or fax to:** 360-923-2608 (Effective January 1, 2012, fax to 360-586-2288)

2012 PEBB MEDICAL CONTRACTORS

Group Health Cooperative, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233 **1-888-901-4636 or TTY 1-800-833-6388**

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099 **1-800-813-2000 or TTY 1-800-735-2900**

Premera Blue Cross, P.O. Box 327, Seattle, WA 98111-0327 **1-800-817-3049 or TTY 1-800-842-5357**

Uniform Medical Plan, administered by Regence BlueShield of Washington, P.O. Box 91015, MS BU248, Seattle, WA 98111-9115 **1-888-849-3681 or TTY 711**

2012 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157 **1-800-650-1583**

Uniform Dental Plan, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157 **1-800-537-3406**

Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124-5611 **1-855-433-6825**

2012 PEBB LIFE INSURANCE CONTRACTOR

ReliaStar Life Insurance Company, P.O. Box 20, Route 7325, Minneapolis, MN 55440-0020 **1-866-689-6990**